VERMONT
DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH UPDATE
July 15, 2009

Pieces Of History In Vermont Mental Health

The "Pieces of History" series in the Mental Health Update describes key events and significant policy milestones in the evolving Mental Health Systems of Care, thus, connecting our past to the present.

1988 Vermont's Act 264 clearly addressed the major concerns expressed by families, providers, advocates, and stakeholders in the 1980s through several strategies designed to create a coordinated interagency system of care. One of the fundamental aspects of the Act was to create **an interagency definition of *severe emotional disturbance***.

All the testimony heard by the Child and Adolescent Service System Project (CASSP) Steering Committee agreed that families were frequently told by agencies that their child did not quite fit the legal charge of this particular agency and, therefore, they should try a different agency to find the services (and funding to provide those services) that they needed. The task of writing the definition for the legislation that would work for everyone in the state's public sector proved to be the most difficult section of the proposed legislation to draft. An underlying issue was the meeting of two very different service cultures: mental health and education. Psychiatrists and other mental health professionals expressed the need for a definition that included the children and families who sought help with a wide variety of mental health issues and diagnoses. Educators expressed the need to accommodate the federal definition of "serious emotional disturbance" and determined which children they could serve through special education. Eventually the subcommittee and the full Steering Committee concluded their work with a clear and inclusive definition that all Vermont departments have now used for 20 years. The definition of a "child or adolescent with a severe emotional disturbance" can be found at http://healthvermont.gov/mh/legislation/documents/ACT264.pdf

CHILDREN'S MENTAL HEALTH

Progress with Vermont Youth Suicide Prevention Coalition

The Vermont Youth Suicide Prevention Coalition (VYSPC) convened the third meeting to continue its work on creating broad-based support for youth suicide prevention planning in Vermont. The formation of VYSPC was considered a primary objective of the 1.5 million dollar Youth Suicide Prevention Grant, which was awarded by the

Substance Abuse and Mental Health Services Administration (SAMHSA) to the Center for Health and Learning, as part of the Garrett Lee Smith Memorial Act funding.

The May meeting featured a presentation by Ken Norton of the New Hampshire National Alliance for the Mentally Ill on the *Connect* model, which focuses on early intervention around mental health conditions and the importance of building community-based response systems. The group talked about how the NH model might be adapted for implementation in Vermont.

Other topics of discussion included:
- ✧ the possible reasons why people don't talk openly about suicide;
- ✧ the debate over whether suicide or depression is the public health problem;
- ✧ the importance of using gatekeepers in school along with screening;
- ✧ the Coalition's social marketing campaign to de-stigmatize mental health concerns; and
- ✧ the preparation of a statewide youth suicide prevention kick-off event in September.

For more information on the Vermont Youth Suicide Prevention Project, contact: Brian Remer, Center for Health and Learning, (tel): 802-254-6590, (fax): 802-254-5816, brian@healthandlearning.org.

Visitors, Training, and Planning for Youth in Transition Grant

From July 8-10, the Youth in Transition (YIT) Operations and Outreach Team hosted four visitors from the federal TA Partnership: Kim Williams, Gwen White, Brittany Couch, and Simon Gonsoulin. These TA providers also met with the YIT Leadership Team and attended the July 9 *Sequential Intercept Model* training at the Elks Club in Montpelier. They were quite interested in and supportive of Vermont's focus on a young-adult driven system of care, as well as on a broad public health approach to mental health issues. Their visit will result in a plan to guide future interactions between the TA Partnership and the Vermont system of care. Simon, the TA Partnership's juvenile justice specialist, was especially pleased to have the opportunity on July 9 to talk with Chief Justice Paul Reiber and with Judge Edward Cashman, who stayed throughout the day to participate in the Chittenden County regional YIT planning. With 150 people present for the Sequential Intercept Model training, we really did start a dialogue between the fields of criminal justice and of children's mental health. We look to the regional planning and management teams for the Youth in Transition grant to keep the dialogue going.

Waiver Name Changed

The name of the **Children's Mental Health Home and Community Waiver** has been changed. Logic was behind the change because Vermont's Global Commitment Waiver is an overall state waiver, and we do not need a waiver to this larger waiver. After much discussion about many different names, the name ***Enhanced Family Treatment (EFT)*** was selected. We wanted to reflect the work done with families and did not want to call it intensive because there is much intensive treatment happening outside of the waiver. We felt enhanced best reflected the purpose of this funding - to enhance an already existing treatment plan.

Advisory Board Appointments

The Governor's Office has appointed members to the Act 264 Advisory Board. Under Vermont's Act 264 and the 2005 Interagency Agreement between the Agency of Human Services and the Department of Education, this Board advises the relevant state department and agency heads about the development and functioning of the interagency system of care for children and youth with any of the fourteen disabilities defined in special education law and their families. Appointees are as follows.

~ Julia Haynes, Woodstock ~ Bob Kline, Bradford ~ Cinn Smith, Fair Haven
~ Ted Tighe, Middlebury ~ Julie Welkowitz, Richmond

Intensive Family Based Services and Access Workgroup

This workgroup was formed earlier this year to review and restructure the current Intensive Family Based Services (IFBS) and Access programs. The workgroup meets monthly with the goal to identify the elements from current research and existing programs to include in a new version of IFBS and Access. The group has been reviewing the current practices for family stabilization and treatment offered through each system partner. The workgroup is composed of the following partners:

- Department of Mental Health (DMH)
- Department for Children and Families' (DCF) Family Services Division
- Department of Health's (VDH) Alcohol and Drug Abuse Programs (ADAP)
- Juvenile Justice (JJ) and
- The community provider system.

This month, the agenda included discussion of the family focused services offered through one of ADAP's service providers, the Lund Family Center. Lund gave an overview of the Children's Treatment Services and a pilot project for co-located and coordinated child welfare and substance abuse service interventions. The primary purpose of including "substance abuse" as an issue in need of attention through programs such as IFBS/ACCESS is that substance use/abuse/dependence can have an impact on parenting. A worker in these programs will need to be trained and supported to effectively embed substance abuse screening in the assessment process. An understanding of the process of treatment and recovery is essential for IFBS/ACESS workers to be supportive of the family, as treatment and recovery can bring significant changes in family dynamics.

The group also heard an overview of the Family-Based Treatment approach designed by the Vermont Center for Children, Youth and Families of FAHC/UVM Pediatric Psychiatry. The Family-Based Treatment approach emphasizes the family, not just the child, as the focus for evidence-based assessment and treatment. This approach includes a strong emphasis on wellness activities for health promotion & illness prevention, and evidence-based treatment intervention according to family members' need.

The workgroup will consider how to incorporate elements of wellness activities, building resiliency, family-focused assessment and treatment, screening for substance use, and developing a co-occurring capable workforce as the IFBS/ACCESS programs are restructured. The workgroup meets again in early August.

FUTURES PROJECT

SRR Architectural Design Group

Architecture Plus revised their preliminary draft program of space for the Secure Recovery Residence (SRR) in concert with recovery programming needs developed by stakeholders during two planning meetings in June. Frank Pitts of Architecture + reviewed alternative models for configuring the space, each of which is designed to achieve separation of the residential living areas from the work activity areas. One model is more linear, a second model more clustered, and a third combines elements of both. The initial meetings of the design group identified space needs for a variety of purposes and activities, increasing the potential number of overall square feet beyond the original 20,000 square foot estimated. Changes presented to the design group make the spaces more flexible while reducing the total square feet and number of rooms. One group room will also function as the library while the other group room will serve as a classroom. Of the two multi-purpose rooms, one is quiet, while the other accommodates activities that may involve music, noise, art projects, and other activities. The exercise room was retained. Configuration of space is still very much in play as Architecture Plus incorporates ideas and suggestions from the meetings of the clinical recovery programming and the architectural design groups. Asked by Architecture + to provide advice regarding the space needs of SRR staff, DMH will convene a phone conference to review the staffing plan and think through the office area of the facility to accommodate charting, consultations, locker and team room needs. Creation of a beautiful environment as home-like as possible within the construct of a secure facility remains a fundamental goal. Bedrooms will not all be alike in shape and natural light will be optimized. The building itself will present an attractive face and will have roof lines, materials, and other architectural features that give it a residential scale.

The next architectural design meeting will include a revised model of space and the site options for the SRR. It will be August 4th from 10:00 to 1:00 in Waterbury.

VSH Staff Focus Groups Offer Recommendations for Proposed SRR Facility

Three successive one hour meetings were held with VSH staff at 7 a.m., 1:30 p.m. and 3:00 p.m. on June 25. The purpose of the meetings was to provide information about the status of planning for the Secure Recovery Residence and to hear staff ideas for recovery programming and architectural design of the new facility. Many of the practical suggestions for improving the lives of the residents and enhancing the environment of the SRR were similar to those heard in previous focus groups of patients and other stakeholders (importance of individual rooms, more space, more exercise areas, access to light, fresh air, access to outdoors, soft, soothing colors, etc.). The main themes emerging from these discussions are presented below.

1. Staff clearly felt that an expanded physical space inside the SRR and access to a large outside area would serve to reduce tensions and could likely reduce the current level of 1-1 staff monitoring of patient behavior.

2. The SRR should have rich and varied programming within the treatment milieu that would support a wide range of substantive education, training and work opportunities as well as provide opportunities for self-expression and learning---of social and life skills as well as vocational and educational competencies.

3. Recovery planning and treatment should be based on a comprehensive admissions assessment that takes into account past history, including trauma, and current functional abilities. Individual objectives for growth, collaboratively arrived at with staff, should be the basis for an individual's recovery plan and that progress in these areas would be the basis for access to greater levels of responsibility requiring less program-provided structure. Ultimately progress in skills and social functioning based on the recovery objectives would lead to graduation to another, less restrictive facility.

4. There should be consistency of approach across treatment system boundaries (e.g., reduction / elimination of restraint & seclusion should be a common goal across the delivery system. There should be a common approach to treatment among community care managers and the SRR.).

5. On-going staff education and training will be central to the success of the SRR and should be built into the SRR plan.

6. VSH staff appreciate and want to be included in the planning process. It permits them to use their experience to contribute to the creation of a program that can improve the lives of their patients. And it may smooth the implementation process of transferring patients from VSH to the SRR

VERMONT STATE HOSPITAL

Jim Huitt Joins VSH Psychology Service

On July 13, 2009 Jim Huitt, PsyD will be joining the Psychology Service on a fulltime basis. Jim brings extensive experience to the position. He has worked as the Director of Central Vermont Substance Abuse Services, a member of the Psychiatry/Psychology Consult Service at FAHC and the Director of the Mobile Crisis Team and ASSIST Program for Howard Center for Human Services. Jim has long term experience working with severe and persistent mental illness (and even some of our current residents). Please welcome Jim and help make his transition to VSH as pleasant as is possible.

The Psychology Department will continue to function as a referral service. We will continue to focus our efforts on developing behavioral interventions, psychometric assessments as necessary, individual therapy, education and group therapy offered in the Treatment Mall. Attendance at rounds will be a regular occurrence, with one of us attending meetings on all three units.

VERMONT STATE HOSPITAL CENSUS

The Vermont State Hospital Census was 43 as of midnight Monday. The average census for the past 45 days was 48.6.